1. Background/Setting the Stage—Users/Uses of Patient Records
   1. Who may see records?

* specialists—neurologists
* home care nurse
* HMO
* acute hospital
* PT/OT
* rehab unit
* students, residents
* quality review committee—hospital, rehab unit, home health agency, HMO
* PH department
* researchers
* attorneys
* paralegals
* expert witnesses
* court (judge)
* researchers
  1. What for?
* coordinate care—communicate essential info to healthcare team, including payers (financing)
* assess quality of care—quality improvement committee, accrediting/licensing agencies, payers
* minimizing risk—malpractice
* train students—medical/nursing/health science, residents/fellows
* conduct research
  1. inadequate/altered records—how adversely affect patient?
* medical errors
* ↓ quality of care/outcome
* insurance denial
* ↓ damages in lawsuits
  1. Professional Liability—“every medical malpractice suit can be won or lost based on the quality and content of the medical records. A suit without merit can be lost because the medical record was vague, incomplete, or altered. Conversely, a potentially damaging suit can be won because the medical record was precise, thorough, and accurate—and events were well documented”

1. “Good” Documentation
   1. Characteristics:

* discrete and respectful—belligerent patient = “seems drunk” vs. suffering reaction?
* comprehensive/complete/clear/descriptive
* concise—transcription costs per line
* timely
* legible
* accurate
* organized
  1. Incomplete Records—courts have allowed an inference of negligence where medical records fail to include certain data
  2. Descriptive
     + Imprecise “Doing OK”
     + Accurate: “Less pain today. Ate full diet. Fully ambulatory.”
     + General: “Wound OK”
     + Specific: “Surgical incision healing. No sign of infection.”
     + Avoid imprecise language, generalizations, etc.
  3. 3 Rules of Charting
     1. No record = Didn’t happen
     2. Illegible = Worthless
     3. Unorganized = No Value

1. Risk Management
   1. Approved Abbreviations—JCO

* Don’t use “u”—write “units”—mistaken for 0, 4, or cc
* Don’t use Q.D. or QOD—write “daily” or “every other day”
* Don’t use tailing zeros (X.0 mg), lack of leading zero (.X mg)—write “X mg” or “0.X mg”
  1. Errors Correction– Inaccurate or Incomplete?
     + Altered Records
       - penalty
         * jeopardize malpractice defense
         * liability insurer could cancel coverage
         * criminal charges for fraud and perjury—fine/imprisonment
         * medical license revoked for unprofessional conduct
       - never alter patient record!
     + Correcting the Patient Record
       - Errors—inaccurate?—5 elements:
         * single strike-through line
         * initials
         * date (including year)
         * time (military time or designate am/pm)
         * identified as “error”
       - Errors—incomplete?
         * can use carrot to input
         * date annotation truthfully—never backdate an entry
         * specify that you are adding it after the fact

date, time

signature/initials

* + - Updating the Patient Record

1. SOAP Note
   1. Subjective → only part used in 1st year
      1. information obtained from patient and/or family (history)
      2. includes chief complaint (CC), history of present illness (HPI), and pertinent portions of past, family, and personal/social histories and *review and systems (ROS)*
      3. put patient’s exact words in quotes for CC
   2. Objective
      1. information from your observations (e.g. physical exam findings or vital signs)
      2. includes lab results and other diagnostic study results (e.g. x-rays)
   3. Assessment
      1. describes your impression of the current medical problems
      2. includes differential diagnosis and/or your reasoning behind your medical impressions—“Cystitis—symptoms of dysuria and findings on urinalysis suggest urinary tract infection”
   4. Plan
      1. plan for treatment and follow-up
      2. may include medications or additional diagnostic studies and therapies
         1. “Treat with 3-day course of antibiotics (Bactrim DS one twice a day)”

# Example

S: **6-year-old** here because of **“right ear pain and fever” for 3 days**. Developed a new rash on chest last week. Has wheezing problems during soccer; has been out of previously prescribed medications for 6 weeks including albuterol and cromolyn sodium inhalers because mother thought they were no longer needed. Overdue for immunizations. No known medication allergies.

O: Fussy, well-hydrated. **T 101.9F**. Left TM clear, **right TM bulging and red**. Ringlike scaly reddish lesions on torso. The torso lesions have hyphae on KOH preparation. Lungs with diffuse end-expiratory wheezing, otherwise clear.

A: #1 – **Acute otitis media (OM), right**

#2 – Tinea corporis (ringworm)

#3 – Asthma, mildly flared off meds

#4 – Needs immunizations

P: #1 – **Amoxicillin 250 mg tid 10 days for OM**

#2 – Clotrimazole cream applied bid for tinea corporis

#3 – Albuterol and cromolyn inhalers qid for asthma

#4 – Update immunizations

#5 – **Recheck in 14 days and as needed**

1. Example – Documenting a Chief Complaint (CC) and History of Present Illness (HPI)

CC: “pain behind right knee” for 3 days

Location—behind right knee; radiated above knee 2 days ago.

Quality—throbbing

Quality—tolerable; got worse 2 days ago {pain rating scale?}

Timing—started all of a sudden 3 days ago; got worse 2 days ago; all the time

Setting—all the time; may have bumped it

Remitting/Exacerbating—stretch out leg, lying down; standing, walking, touching area

Associated Manifestations—above knee 2 days ago

Patient’s Perspective—thought she may have bumped it but no bruising

Medication/Allergies/Substance Use

Medication—Estrostep

Allergy—codeine

Substances—none

**CC/HPI**: Ms. Jones is a 39-year-old, single Caucasian female who presents with a chief complaint of constant pain behind the right knee that developed suddenly 3 days ago. Thought she may have bumped her leg but saw no bruising. It is a throbbing pain that is tolerable but worsened and radiated above the knee 2 days ago. Standing, walking or touching the area worsens the pain. Gets some relief when lying down and from stretching out her leg while seated. Takes Estrostep to regulate periods. Allergic to codeine. Does not smoke, drink alcohol, or use illicit drugs.

Checklist for a Clear and Accurate Record (Bates)

1. Is the order clear?
   1. make headings clear (history, physical exam, etc.)
   2. accent your organization with indentations and spaces
   3. arrange the *present illness* in chronologic order, starting with the current episode then filling in relevant background information
2. Do the data included contribute directly to the assessment?
   1. spell out supporting evidence (positive and negative) for every problem or diagnosis
   2. use sufficient detail to support your assessment and plan
3. Are pertinent negatives specifically described?
   1. record the “pertinent negatives”
   2. ex. for bruising, record absence of injury or violence, familial bleeding disorders or medications or nutritional deficits that might lead to bruising
   3. ex. for pt who is depressed but not suicidal, record both facts
4. Are there overgeneralizations or omissions of important data?
   1. *Data not recorded are data lost.*
   2. don’t assume you’ll remember any details
5. Is there too much detail?
   1. avoid repetition of information or redundancy
   2. omit most negative findings unless they relate directly to the pt’s complaints or to specific exclusions in your diagnostic assessment
   3. do not list abnormalities that you did not observe; instead, concentration on a few major ones
6. Are phrases and short words used appropriately? Is there unnecessary repetition of data?
   1. omit unnecessary words—saves valuable time and space
   2. omit repetitive introductory phrases such as “The patient reports with…”
   3. Use short words instead of longer, fancier ones (felt instead of palpated, heard instead of auscultated)
   4. describe what you observed, not what you did (“optic discs seen” → “disc margins sharp”)
7. Is the written style succinct? Are there excessive abbreviations?
   1. Words and brief phrases are common
   2. only use abbreviations and symbols that are readily understood
   3. an overly elegant style is less appealing than a concise summary
   4. be sure your record is legible
8. Are diagrams precise measurements included where appropriate?
   1. diagrams add greatly to the clarity of record
   2. make accurate evaluations of size in centimeters (not in fruits, nuts or veggies—“pea sized” is not good)
9. Is the tone of the write-up neutral and professional?
   1. Be objective. Never use inflammatory or demeaning words.
   2. Use professional language.

**Documentation Checklist**

**Clinical Decision Making I**

The following checklist should be used to guide your documentation of a standardized patient’s chief complaint and history of present illness. Summative skills assessments will include items from this checklist.

|  |  |  |  |
| --- | --- | --- | --- |
|  | The student’s documentation included the following elements and characteristics (format, content, accurate, and complete): | Yes | No |
| 1. | Patient name (last name, first name) | 0 | 0 |
| 2. | Medical record number | 0 | 0 |
| 3. | Date | 0 | 0 |
| 4. | Chief complaint (*in patient’s own words – in quotes*) | 0 | 0 |
|  | History of present illness: |  |  |
|  | Attributes of a symptom: |  |  |
| 5. | Location | 0 | 0 |
| 6. | Quality | 0 | 0 |
| 7. | Quantity / Severity (for pain, rating on a scale of 1-10 [identify]) | 0 | 0 |
| 8. | Timing (onset / duration / frequency) | 0 | 0 |
| 9. | Setting in which it occurs | 0 | 0 |
| 10. | Remitting/relieving factors | 0 | 0 |
| 11. | Exacerbating/aggravating factors | 0 | 0 |
| 12. | Associated manifestations (symptoms) | 0 | 0 |
| 13. | Patient’s perspective | 0 | 0 |
| 14. | Medications (name, dose, route, and frequency of use) | 0 | 0 |
| 15. | Allergies (agent and reaction) | 0 | 0 |
|  | Substance use: |  |  |
| 16. | Tobacco (type and quantity/frequency) | 0 | 0 |
| 17. | Alcohol (type and quantity/frequency) | 0 | 0 |
| 18. | Illicit drugs (type and quantity/frequency) | 0 | 0 |
| 19. | Signature | 0 | 0 |
| 20. | Printed name (below signature) | 0 | 0 |
| 21. | Proper procedure used to correct errors (or no errors) | 0 | 0 |
| 22. | *Narrative / paragraph format* (short phrases) | 0 | 0 |
| 23. | Legibility | 0 | 0 |
| 24. | Note written in ink (blue or black) | 0 | 0 |
|  | Comments: |  |  |

Required Reading: *Bates’ Guide to Physical Examination and History Taking (2009)*

Chapter 2, Clinical Reasoning, Assessment, and Recording Your Findings, pp. 40-43